

Division of Health Care Facilities

PRINTED: 05/31/2013
FORM APPROVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: TN7201	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 05/30/2013
NAME OF PROVIDER OR SUPPLIER LAURELBROOK SANITARIUM		STREET ADDRESS, CITY, STATE, ZIP CODE 114 CAMPUS DRIVE DAYTON, TN 37321			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
N 000	Initial Comments During the annual Licensure survey conducted on May 28-30, 2013, at Laurelbrook Sanitarium, no deficiencies were cited under Chapter 1200-8-6, Standards for Nursing Homes.	N 000			

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REGULATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

STATE FORM

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4XKZ11

If continuation sheet 1 of 1